

Reid Stell Counseling

Authorization to Release Confidential Information

Client Name: _____ **Date of Birth:** _____

Information to be Released TO:

Name: _____
Organization: _____
Address: _____

City State Zip

Information to be Released BY:

Reid Stell
Reid Stell Counseling
14535 Bel-Red Rd, Suite B-202
Bellevue, WA 98007

Phone: _____
Fax: _____

Ph: 206.457.3038
Fax: 206.858.9206

Purpose of Disclosure:

Specific Information to be Disclosed:

Specify Dates of Service to be Released: From: _____ To: _____

Expiration Date or Event: _____

Specific Authorization:

I understand that my records may contain information regarding testing, diagnosis and/or treatment of HIV/AIDS or other sexually transmitted diseases. I give specific authorization for these records to be released.
(Per RCW 70.24.105). Yes _____ No _____ Client Initials _____

I Understand:

1. My records are protected under the Federal and State statutes and cannot be disclosed without written consent unless otherwise provided for in the regulations.
2. I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
3. This authorization for release of healthcare information expires in 90 days, unless sooner revoked by me in writing.
4. There may be charges associated with your request for records. Such charges shall not exceed the amounts allowable under RCW 70.02.
5. That, when necessary, portions of my records may be faxed.
6. A photocopy of this authorization shall have the same effect as the original.
7. My records contain mental health information and I give my specific authorization for these records to be released.
8. My records may contain information regarding diagnosis and/or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released.

Any minor children thirteen (13) years or older has all the rights provided by Chapter 275-56 WAC to clients receiving outpatient services. Therefore, these minor clients must sign authorization for release of client information. In addition, it is the policy of Reid Stell Counseling to require the signed consent of a legal guardian in addition to that of the minor client.

Signature of Client: _____ **Date:** _____

Signature of Guardian: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

All sections on this consent form must be completed for this release to be valid.